VERIFICATION FOR STATE COMPENSATION

I _____, PROSECUTING ATTORNEY OF _____ COUNTY, HEREBY AFFIRM THAT I HAVE APPOINTED:

Name:
Work Address/Telephone:
Home Address/Telephone:
Social Security Number:

to the position of: (Check one of the following):

- ☐ Full-time Chief Deputy Prosecutor (IC 33-14-7-2(a))
- ☐ Part-time Chief Deputy Prosecutor (IC 33-14-7-2(a))
- ☐ Full-time Prison Deputy Prosecutor (IC 33-14-7-2(b) or (c))
- ☐ Part-time Prison Deputy Prosecutor (IC 33-14-7-2(b) or (c))
- ☐ Full-time Mental Health Prosecutor (IC 33-14-7-2(d))
- ☐ Part-time Mental Health Deputy Prosecutor (IC 33-14-7-2(d))

The above-noted individual was appointed effective, _____(date). I affirm that such person is entitled to compensation as provided by law.

Pursuant to Indiana Administrative Rule 5 (C), I acknowledge that I will notify the Division of State Court Administration, on forms approved by that agency, within two weeks of any change in the above-noted individual's employment status.

_____ _____

Prosecuting Attorney's Signature Date

_____

Typed or printed name

Please complete and return this original, signed form by 1/31, to:

Division of State Court Administration
ATTN: Payroll Department
115 West Washington Street, Suite 1080
Indianapolis, Indiana 46204-3417

FAXED forms are not acceptable

VC-F2 (REV. 9-97)